CITY OF HANNIBAL AND BOARD OF PUBLIC WORKS
Medical Benefit Plan
Plan Document and Summary Plan Description
Amendment No. 4

For the City of Hannibal and Board of Public Works Medical Benefit Plan, Plan Document and Summary Plan Description which is effective January 1, 2021, City of Hannibal and Board of Public Works hereby amends such document as of January 1, 2022 as follows:

Throughout the entire document, DELETE:

Elixir

And REPLACE with:

EmpiRx Health

Throughout the entire document, DELETE:

Elixir
Attn: DMR Department
8935 Darrow Rd.
PO Box 1208
Twinsburg, OH 44087
Fax: 1-866-646-1403

And REPLACE with:

EmpiRx Health
P.O. Box 1339
Mechanicsburg, PA 17055
Phone: 1-877-241-7123
www.empirxhealth.com

Under SECTION I—INTRODUCTION, A. Quick Reference Information Chart - For Help or Information DELETE:

Prescription Drug Program • Retail *Network Pharmacies* • Mail Order (Home Delivery) *Pharmacy* • *Prescription Drug* Information & *Formulary* • Preauthorization of Certain Drugs • Reimbursement for *Non-Network* Retail *Pharmacy* Use • Specialty Pharmacy Program	**Retail** Elixir 8935 Darrow Rd. PO Box 1208 Twinsburg, OH 440877 Phone: 1-800-361-4542 Fax: 1-866-646-1403 www.elixirsolutions.com

Approved by Board 3.14.2022 AJ

And REPLACE with:

Prescription Drug Program • Retail *Network Pharmacies* • Mail Order (Home Delivery) *Pharmacy* • *Prescription Drug* Information & *Formulary* • Preauthorization of Certain Drugs • Reimbursement for *Non-Network* Retail *Pharmacy* Use • Specialty Pharmacy Program	**Retail** EmpiRx Health PO Box 1339 Mechanicsburg, PA 17055 Phone: 1-877-241-7123 www.empirxhealth.com

After SECTION II—, ADD and RENUMBER subsequent items:

SECTION III - CONSOLIDATED APPROPRIATIONS ACT OF 2021

The Consolidated Appropriations Act of 2021 (CAA) is a federal law that includes the No Surprises Billing Act as well the provider transparency requirements that are described below. Enforcement dates, standards for implementation (good faith, reasonable), and guidance offered by federal entities directly impact actions or availability of the below outlined services by the *Third Party Administrator* and the *network*.

A. Surprise Billing Claims

Surprise billing claims are claims that are subject to the No Surprises Billing Act requirements:

1. emergency services provided by *non-network* providers
2. covered services provided by a *non-network* provider at a *network* facility
3. *non-network* air ambulance services

B. No Surprises Billing Act Requirements

Emergency Services

As required by the CAA, emergency services are covered under your *Plan*:

1. without the need for *pre-certification*
2. whether the provider is *network* or *non-network*

If the emergency services you receive are provided by a *non-network* provider, covered services will be processed at the *network* benefit level.

Note that if you receive emergency services from a *non-network* provider, your out-of-pocket costs will be limited to amounts that would apply if the covered services had been furnished by a *network* provider. However, *non-network cost-sharing amounts* (i.e., *co-payments*, *deductibles*, and/or *co-insurance*) will apply to your *claim* if the treating *non-network* provider determines you are stable, meaning you have been provided necessary emergency care such that your condition will not materially worsen and the *non-network* provider determines that:

1. you are able to travel to a *network* facility by non-emergency transport
2. the *non-network* provider complies with the *notice* and consent requirement
3. you are in condition to receive the information and provide informed consent

If you continue to receive services from the *non-network* provider after you are stabilized, you will be responsible for the *non-network cost-sharing amounts*, and the *non-network* provider will also be able to charge you any difference between the *maximum allowable amount* and the *non-network* provider's billed charges.

This *notice* and consent exception does not apply if the covered services furnished by a *non-network* provider result from unforeseen and urgent medical needs arising at the time of service.

Non-Network Services Provided at a Network Facility

When you receive covered services from a *non-network* provider at a *network* facility, your *claims* will be paid at the *non-network* benefit level if the *non-network* provider gives you proper *notice* of its charges, and you give written consent to such charges. This means you will be responsible for *non-network cost-sharing amounts* for those services and the *non-network* provider can also charge you any difference between the *maximum allowable amount* and the *non-network* provider's billed charges.

This requirement does not apply to ancillary services. Ancillary services are the following services:

1. emergency services
2. anesthesiology
3. pathology
4. radiology
5. neonatology
6. diagnostic services
7. assistant surgeons
8. hospitalists
9. intensivists
10. any services set out by the U.S. Department of Health & Human Services

In addition, this *notice* and consent process will not apply to you if there is no *network* provider in your area who can perform the services you require.

Non-network providers satisfy the *notice* and consent requirement by one (1) of the following:

1. by obtaining your written consent not later than seventy-two (72) hours prior to the delivery of services
2. if the *notice* and consent is given on the date of the service, if you make an appointment within seventy-two (72) hours of the services being delivered

The *network* is required to confirm the list of *network* providers in its provider directory every ninety (90) days. If you can show that you received inaccurate information from the *network* that a provider was *in-network* on a particular *claim*, then you will only be liable for *network cost sharing amounts* (i.e., *co-payments*, *deductibles*, and/or *co-insurance*) for that *claim*. Your *network* cost-shares will be calculated based upon the *maximum allowed amount*. In addition to your *network* cost-shares, the *non-network* provider can also charge you for the difference between the *maximum allowed amount* and their billed charges.

C. How Cost-Shares Are Calculated

Your cost shares for emergency services or for covered services received by a *non-network* provider at a *network* facility, will be calculated using the median plan *network* contract rate that we pay *network* providers for the geographic area where the covered service is provided. Any out-of-pocket cost shares you pay to a *non-network* provider for either emergency services or for covered services provided by a *non-network* provider at a *network* facility will be applied to your *network out-of-pocket limit*.

D. Appeals

If you receive emergency services from a *non-network* provider or covered services from a *non-network* provider at a *network* facility and believe those services are covered by the No Surprise Billing Act, you have the right to appeal that *claim*. If your appeal of a *surprise billing claim* is denied, then you have a right to appeal the adverse decision to an independent review organization as set out in the **Claims and Appeals** section of this summary plan description.

E. Transparency Requirements

The *network* provides the following information on its website (i.e., **www.healthlink.com**:

1. protections with respect to *surprise billing claims* by providers

2. information on contacting state and federal agencies in case you believe a provider has violated the No Surprise Billing Act's requirements

The *Third Party Administrator*, through Member Services at the phone number on the back of you ID card, will allow you to get:

1. a list of all *network* providers

In addition, the *Third Party Administrator* will provide access through its website to the following information:

1. *network* negotiated rates
2. historical *non-network* rates

F. Continuity of Care

If the *network* provider leaves the *network* for any reason other than termination for cause, and you are in active treatment, you may be able to continue seeing that provider for a limited period of time and still get *network* benefits. "Active treatment" includes:

1. an ongoing course of treatment for a life-threatening condition
2. an ongoing course of treatment for a serious acute condition (e.g., chemotherapy, radiation therapy, and post-operative visits)
3. pregnancy and through the postpartum period, or
4. an ongoing course of treatment for a health condition for which the *physician* or health care provider attests that discontinuing care by the current *physician* or provider would worsen your condition or interfere with anticipated outcomes

An 'ongoing course of treatment' includes treatments for mental health and substance use disorders.

In these cases, you may be able to continue seeing that provider until treatment is complete, or for ninety (90) days, whichever is shorter. If you wish to continue seeing the same provider, you or your doctor should contact customer care for details. Any decision by *Third Party Administrator* regarding a request for Continuity of Care is subject to the process as listed out **in the Claims and Appeals** section.

Under SECTION IV—SCHEDULE OF BENEFITS, B. Schedule of Medical Benefits, Pre-Certification DELETE:

17. specialty infusion/injectable medications over $1,000 per infusion/injection which are covered under the medical benefits and not obtained through the Prescription Drug Benefits (i.e. provided in an *outpatient* facility, *physician's* office, or home infusion)

Following SECTION IV—SCHEDULE OF BENEFITS, B. Schedule of Medical Benefits, Pre-Certification ADD:

Pre-determination is strongly recommended for specialty infusion/injectable medications which are covered under the Medical Benefits and not obtained through the Prescription Drug Benefits (i.e. provided in an *outpatient* facility, *physician's* office, or home infusion), over $1,000 per infusion/injection.

Under SECTION IV—SCHEDULE OF BENEFITS, J. Schedule of Medical Benefits, Deductible, per Calendar Year DELETE:

Non-Embedded: Individual Plan	$500	$1,000	$2,000

And REPLACE with:

Per *plan participant*	$500	$1,000	$2,000

Under SECTION IV—SCHEDULE OF BENEFITS, J. Schedule of Medical Benefits, Maximum Out-of-Pocket Limit, per Calendar Year DELETE:

Non-Embedded: Individual Plan	$2,500	$3,000	$5,000

And REPLACE with:

Per *plan participant*	$2,500	$3,000	$5,000

Under SECTION IV—SCHEDULE OF BENEFITS, J. Schedule of Medical Benefits DELETE:

The *Plan* will pay the designated percentage of *covered charges* until *out-of-pocket limits* are reached, at which time the *Plan* will pay 100% of the remainder of *covered charges* for the rest of the *calendar year* unless stated otherwise.

NOTE: The following charges do not apply toward the out-of-pocket limit amount and are generally not paid by the Plan:

1. cost containment penalties
2. amounts over *the maximum allowable charges*
3. charges not covered under the *Plan*
4. *balanced billed* charges
5. *pre-certification* penalties

And REPLACE with:

The *Plan* will pay the designated percentage of *covered charges* until *out-of-pocket limits* are reached, at which time the *Plan* will pay 100% of the remainder of *covered charges* for the rest of the *calendar year* unless stated otherwise.

NOTE: The following charges do not apply toward the out-of-pocket limit amount and are generally not paid by the Plan:

1. cost containment penalties
2. amounts over *the maximum allowable charges*
3. charges not covered under the *Plan*
4. *balanced billed* charges
5. *pre-certification* penalties
6. *prescription drug* charges

Under SECTION IV—SCHEDULE OF BENEFITS, K. Schedule of Prescription Drug Benefits DELETE:

Prescription drug charges do apply to the medical *deductible*.

And REPLACE with:

Prescription drug charges do not apply to the medical *deductible*.

Under SECTION IV—SCHEDULE OF BENEFITS, K. Schedule of Prescription Drug Benefits DELETE:

Specialty Drug Prescription Out-of-Pocket Limit, Per Calendar Year	
Per *plan participant*	$2,500

Under SECTION IV—SCHEDULE OF BENEFITS, K. Schedule of Prescription Drug Benefits DELETE:

Certain *preventive care prescription drugs* received by a *network pharmacy* are covered at 100% and the *deductible/co-payment/co-insurance* (if applicable) is waived.

Please refer to the following websites for information on the types of payable *preventive care prescription drugs*:
https://www.healthcare.gov/coverage/preventive-care-benefits/ or
http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

The *Plan* also covers certain Safe Harbor medications at the preventive rate. For a complete list of preventive and Safe Harbor medications, refer to the Elixir list at **elixirsolutions.com**

And REPLACE with:

Certain *preventive care prescription drugs* received by a *network pharmacy* are covered at 100% and the *deductible/co-payment/co-insurance* (if applicable) is waived.

Please refer to the following websites for information on the types of payable *preventive care prescription drugs*:
https://www.healthcare.gov/coverage/preventive-care-benefits/ or
http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.

The *Plan* also covers certain Safe Harbor medications at the preventive rate. For a complete list of preventive and Safe Harbor medications, refer to the EmpiRx list at **empirxhealth.com**

Under SECTION V—MEDICAL BENEFITS, A. Covered Medical Charges DELETE:

18. **Durable Medical Equipment.** Rental of *durable medical equipment* (*DME*) if deemed *medically necessary*. The total rental fee for *durable medical equipment* will not exceed the purchase price of the equipment. If the purchase price is not available, rental is allowed for the lifetime of the equipment. Delivery or set-up charges are not a benefit of the *Plan*. Benefits are also available for oxygen and its administration, including oxygen concentrators. Oxygen concentrators are not subject to purchase price requirements.

    ***Pre-certification* is required when the purchase price is expected to exceed $1,000.** Failure to obtain *pre-certification* may result in a $500 penalty.

    Replacement of purchased equipment if either:

    a. the replacement is needed because of a change in your physical condition
    b. it is likely to cost less to replace the item than to repair the existing item or rent a similar item

    Maintenance and repairs needed due to misuse or abuse are not covered.

And REPLACE with:

18. **Durable Medical Equipment.** Rental of *durable medical equipment* (*DME*) if deemed *medically necessary*. The total rental fee for *durable medical equipment* will not exceed the purchase price of the equipment. If the purchase price is not available, rental is allowed for the lifetime of the equipment. Delivery or set-up charges are not a benefit of the *Plan*. Benefits are also available for oxygen and its administration, including oxygen concentrators. Oxygen concentrators are not subject to purchase price requirements. Education pertaining to use of *DME* is covered.

    ***Pre-certification* is required when the purchase price is expected to exceed $1,000.** Failure to obtain *pre-certification* may result in a $500 penalty.

    Replacement of purchased equipment if either:

    c. the replacement is needed because of a change in your physical condition
    d. it is likely to cost less to replace the item than to repair the existing item or rent a similar item

    Maintenance and repairs needed due to misuse or abuse are not covered.

Under SECTION V—MEDICAL BENEFITS, A. Covered Medical Charges DELETE:

20. **Genetic/Genomic Testing and Counseling.** Genetic testing to identify the potential for, or existence of, a medical condition (such as a test for the breast cancer gene), as mandated by *PPACA*. Genomic testing to examine abnormalities in groups of genes to aid in designing specific treatment options for an individual's condition, such as cancer. Refer to the **Federal Notices** section, Genetic Information Nondiscrimination Act of 2008 (GINA) subsection.

And REPLACE with:

20. **Genetic/Genomic Testing and Counseling.** Genetic testing to identify the potential for, or existence of, a medical condition (such as a test for the breast cancer gene), as mandated by *PPACA*. Testing for amniocentesis is also covered. Genomic testing to examine abnormalities in groups of genes to aid in designing specific treatment options for an individual's condition, such as cancer. Refer to the **Federal Notices** section, Genetic Information Nondiscrimination Act of 2008 (GINA) subsection.

Under SECTION V—MEDICAL BENEFITS, A. Covered Medical Charges ADD and RENUMBER subsequent items:

34. **National Health Emergency.** In the event of a declared National Health Emergency, the *Plan* will offer coverage as mandated for the condition(s) as outlined in the National Health Emergency, as required by federal regulation. This provision shall override any potentially conflicting, specific exclusions, defined terms, or other *Plan* provisions as necessary to provide, and limited to, any mandated services as outlined in the public health emergency, and corresponding regulation(s). Such coverage shall remain in effect until the public health emergency, as declared by the governing federal agency, has ended.

Under SECTION V—MEDICAL BENEFITS, A. Covered Medical Charges ADD and RENUMBER subsequent items:

35. **Nutritional Counseling.** Nutritional counseling services are covered under then *Plan* when performed as part of diabetic education or in conjunction with a mental health or substance use disorder.

Under SECTION X—CLAIMS AND APPEALS, A. Introduction, DELETE:

TIME LIMIT FOR FILING CLAIMS

All *claims* must be received by the *Plan* within one (1) year from the date of *incurring* the expense, or in accordance with applicable federal government regulations.

The *Plan's* representatives will follow administrative processes and safeguards designed to ensure and to verify that benefit *claim* determinations are made in accordance with governing plan documents and that where appropriate the *Plan* provisions have been applied consistently with respect to similarly situated *claimants*.

And REPLACE with:

TIME LIMIT FOR FILING CLAIMS

All *claims* must be received by the *Plan* within one (1) year from the date of *incurring* the expense, or in accordance with applicable federal government regulations. The *Plan* will accept *network* adjustments of *claims* that are within the *network's* established guidelines.

The *Plan's* representatives will follow administrative processes and safeguards designed to ensure and to verify that benefit *claim* determinations are made in accordance with governing plan documents and that where appropriate the *Plan* provisions have been applied consistently with respect to similarly situated *claimants*.

All other terms and conditions of this City of Hannibal and Board of Public Works Medical Benefit Plan which are not affected by this amendment remain unchanged.

City of Hannibal and Board of Public Works hereby adopts the provisions of this amendment of the City of Hannibal and Board of Public Works Medical Benefit Plan, and its duly authorized officer has executed this amendment.

By: Angela M. Zerbe

Date: 03.16.2022

Title: Chairman - EBTB